

HGOV4100 Fundamentals of health care systems, Fall 2025 - Assessment guidelines –

Both parts shall be answered. Part A will count 40% and part B will count 60% as the grade for the exam is calculated. In *Part A Short answers* you should answer five out of the six questions. In *Part B Essay* you should choose either 1) or 2).

Part A Short answers

Define the following concepts. Illustrate each definition with an example.

1) Asymmetric information

Definition: One actor has more information than another.

Example: A physician has more information of the patient's diagnosis than the patient himself/herself

Comments: Most students (>90%) had correct definition and illustrative examples.

2) Incomplete information

Definition: An actor lacks information of the past when making a decision.

Example: A physician does not have full information of the patient's medical history when making a treatment decision

Comments: Approximately 80% had correct definition and illustrative examples.

3) Prospective payment system

Definition: Provider payment based on fixed prices

Example: The DRG-system, capitation, etc.

Comments: App. 75% got it right. However, quite a few mixed up with when the payment was accomplished, stating that a prospective payment system implies that the budget in total were known to the hospital before a fiscal year started. This is correct only for a capitation system not for an activity-based system where the total budget will depend on activity (however the price will be known ex ante).

4) Risk adjustment

Definition: A method used to account for differences in patient characteristics when comparing healthcare outcomes, costs, or performance across providers, institutions, or time periods.

Example: Adjusting reimbursement rates based on patient characteristics or adjusting per capita payment based on need indexes of a population.

Comments: >90% got it right and had relevant examples. Quite a lot used the risk adjustment in the Netherlands (the subsidy between the solidarity fund and the insurance company) as an example. This is also a nice example.

5) Activity-based financing

Definition: A healthcare provider payment system where hospitals and other healthcare providers receive funding based on the type and volume of treatments or services they deliver, rather than receiving a fixed budget.

Example: Innsatsstyrt finansiering (ISF): Hospitals receive a portion of their funding partly based on activity levels.

Comments: Most students (>90%) had correct definition and illustrative examples.

6) Moral hazard

Definition: A situation where one party is more willing to take risks or behave differently because they don't bear the full consequences of their actions—typically because those consequences are borne by another party.

Examples: People with comprehensive car insurance might drive less carefully than those without insurance. Patients with full insurance coverage may overuse healthcare services or demand unnecessary treatments since they don't pay the marginal cost.

Comments: Most students (>90%) had correct definition and illustrative examples.

Part B Essay

Either

1) Payment systems

Evaluate the implications of payment reform in healthcare systems, using insights from the article by Jegers et al. on healthcare financing and the OECD report 'Better Ways to Pay for Health Care' on innovative payment models. In your essay, address the following aspects:

- Summarize and describe the key types of payment mechanisms discussed by Jegers et al. and the OECD report. Include traditional fee-for-service, capitation, DRG-based financing, bundled payments, and pay-for-performance models.
- Discuss how each payment model aims to address issues like cost containment, healthcare access, and quality improvement. What are the potential incentives or disincentives created by each model, according to the literature?

When writing your essay, provide examples from OECD member countries where specific payment reforms have been implemented and assess their effects on provider practices.

A successful answer can be divided into two: 1) A general presentation of financing systems, including definition of the five payment systems, and 2) a discussion of how the five payments systems affect cost containment, healthcare access, and quality improvement.

The general presentation may start out by Jegers et al.'s 2x2 table where retrospective vs prospective and activity based vs. fixed payment systems make up the two dimensions. Precise definitions of these four concepts are crucial:

- *Retrospective – reimbursements based on actual costs.*
- *Prospective – financing based on expected costs.*
- *Activity based – financing will reflect activity.*
- *Fixed – financing will be independent of activity level (in the short run).*

The five payment systems should be described more in details and placed within the table:

- *Fee-for-service (FFS): Providers are paid separately for each service, procedure, or visit delivered to patients.*
- *Capitation: Providers receive a fixed payment per enrolled patient per time period (usually annually) or per inhabitant in a catchment area.*
- *DRG-based financing: Hospitals receive a fixed payment per patient admission based on their Diagnosis-Related Group classification. The payment is predetermined according to the patient's diagnosis, procedures, and complications, not the actual resources used.*
- *Bundled payments: A single payment covers all services related to a specific treatment episode or condition across multiple providers (e.g., surgery, hospital stay, and post-acute care).*
- *Pay-for-performance (P4P): Payment includes bonuses or penalties based on meeting specific quality metrics, patient outcomes, or efficiency targets.*

All of the five payment systems are prospective payment systems. FFS can also be retrospective. Capitation is a fixed payment system where the provider assumes financial risk for the cost of care. The other payment systems are examples of (more or less) activity-based payment systems.

A discussion of how the five payments systems affect cost containment, healthcare access, and quality improvement should start out with definitions of the three concepts:

- *Cost containment: Strategies and policies aimed at controlling (planned expenditures = actual expenditures) or reducing health expenditures.*
- *Healthcare access: The ability of individuals to obtain needed healthcare services in a timely manner.*
- *Quality improvement: Systematic efforts to enhance patient safety and clinical quality.*

In general, we expect FFS and DRG based financing models to reduce cost containments, improve healthcare access, while the effects on quality improvements are less clear. Capitation is assumed to improve cost containments, reduce healthcare access (unless the fixed budget is set very high), while the effects on quality improvements are less clear. Bundle payments will be somewhere between DRG based and capitation payments, while the P4P have some similarities with FFS (at least as it is implemented for example for GPs in the British NHS).

Most of the students wrote this essay and in general the essays were very good.

or

2) Waiting times and use of private providers

Discuss the implications of outsourcing day surgery to private for-profit entities in the context of managing waiting times in public healthcare systems. Your essay should critically analyze how outsourcing affects patient access to surgical services, the quality of care provided, and the overall efficiency of healthcare delivery.

Drawing on findings from both Siciliani et al.'s work on waiting times and Hagen et al.'s exploration of privatization in day surgery, address the following points:

- Summarize the primary factors contributing to waiting times for elective surgeries, as discussed by Siciliani et al., and explain how waiting times impact patient outcomes and satisfaction.
- Describe the motivations behind outsourcing day surgery to private for-profit entities, referencing key findings from Hagen et al. and evaluate the potential benefits and drawbacks of this outsourcing approach in relation to waiting times.
- Discuss the evidence regarding the quality of care provided in private versus public settings, including considerations of patient complexity and treatment outcomes.

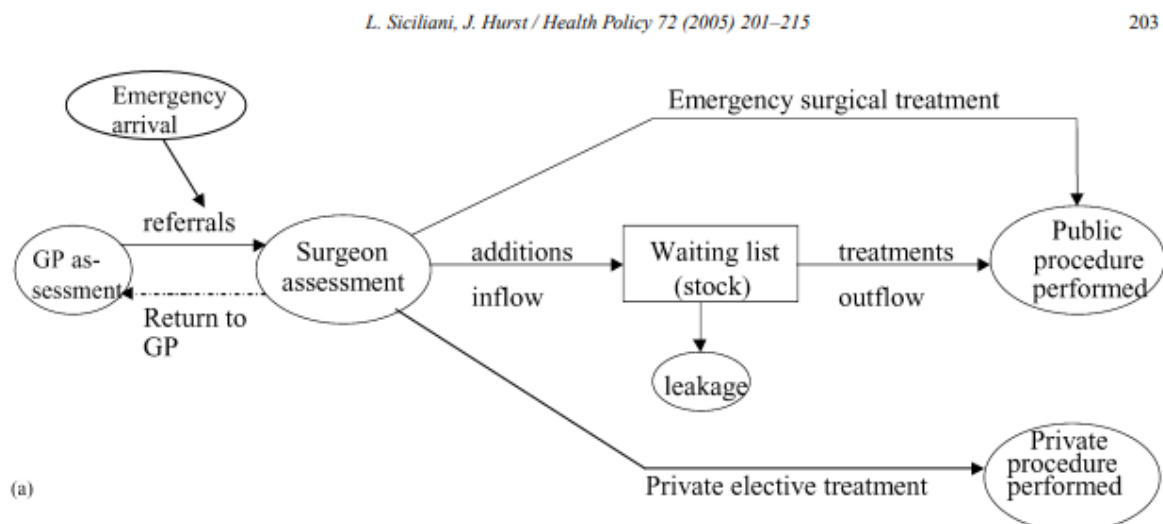
At the end of the essay, reflect on the policy measures that can be implemented to balance the advantages of outsourcing with the need to maintain equitable access and quality in healthcare. Propose recommendations for improving patient access to timely surgical care while ensuring accountability and quality in outsourced services.

A successful answer should start out by defining waiting times. This can be done in several ways. A nice starting point is to define the following intervals:

- *Interval I: Number of days from the day of referral to the day of hospital's evaluation of the GP's referral*
- *Interval II: Number of days from the hospital's evaluation of the GP's referral to the start of the treatments (usually an outpatient consultation)*
- *Interval III: Number of days from the hospital's the start of the treatment to the procedure date (i.e. start of surgery)*

In Norway, official waiting time is defined by interval II.

Siciliani and Hurst depict the process like this:



Siciliani and Hurst further discuss factors affecting waiting times from both the demand side (including health status, technology, severity thresholds, and prices for private suppliers) and the supply side (including capacity in public and private sectors, and productivity).

According to Hagen et al., the motivations behind outsourcing day surgery to private for-profit entities are higher flexibility in setting capacity and lower costs per treatment. The lower costs in private for-profit hospitals are explained by these hospitals' lack of acute services, their ability to streamline treatments, and their focus on low-risk patients.

The quality of care in private hospitals is at least as good as in public hospitals, even after adjusting for patient case-mix. Several factors may explain this finding, primarily that private hospitals employ experienced physicians who often have extensive backgrounds in the public hospital sector(!).

Few students wrote this essay.